PASO Infusion Centre

BY-LAWS for MEDICAL STAFF

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1. KEY POINT SUMMARY

All Accredited Practitioners are expected to:

a) Respect and support PASO Infusion Centre Mission, Vision and Values
b) Attain and maintain excellence in all episodes of patient care through individual and collective activity and close co-operation with PASO INFUSION CENTRE.
c) Treat all staff members with professionalism and respect
d) Abide by these By-Laws
e) Be available for contact at all times, either in person or by his or her deputy who must also be accredited to use the services of PASO INFUSION CENTRE;
f) Notify the Nurse in Charge if Accredited Practitioners if unavailable at any time and nominate an alternative who will care for the patient during period of absence or unavailability.
g) Provide all required entries to the medical record including Medication orders, record assessment and management plan in the Integrated Progress Notes or Clinical Pathway, Final Diagnosis and Discharge Summaries
h) Provide their patients with a full explanation about the patient's proposed treatment and ensure that the patient or their authorised representative sign an appropriate Consent Form.
i) Strictly adhere to PASO INFUSION CENTRE Infection Control procedures relating to patient care
j) Make themselves aware of PASO INFUSION CENTRE emergency procedures
k) Notify the Chief Medical Director in writing if their professional indemnity insurance lapses; their accreditation is withdrawn from any other hospital or medical institution where they have visiting rights; or any restrictions are placed on their registration to practice or their registration is suspended or cancelled.

Preface

The PASO Infusion Centre is a private Day Oncology Service located in Frankston Victoria and established in 2022.

The Chief Executive Officer is responsible for the overall stewardship, strategic direction, governance and performance of the PASO Infusion Centre.

The Chief Executive Officer has approved these By-laws for the health care professionals and the delegations as detailed within these By-laws.

The By-Laws mandate the Accreditation, Credentialing, Re-accreditation and process for defining and amending the Scope of Clinical Practice for Medical Practitioners and other categories of approved health practitioner providing services to patients at the Facility.

Mission, Vision and Values of Facility

Mission

To be the Centre of choice for the provision of Day Oncology Services.

Vision

We lead through research driven, excellence and patient centered care.

Values

- *Collaboration*
- *Excellence*
- *Compassion*
- *Diligence*

Care Statement

Our number one priority is our patient's well-being, who are cared for to the highest standards throughout their treatment journey

PART A – Definitions and Introduction

2. Definitions and Interpretation

Definitions

In these By-laws, unless indicated to the contrary:

Accreditation means the process provided in these By-laws by which a person is Accredited.

Accredited means the status conferred on a Medical Practitioner, Allied Health Professional or other approved category of health practitioner to provide services within the Facility after having satisfied the Credentialing and Scope of Practice requirements provided in these By-laws.

Accredited Medical Officer means a Medical Practitioner who has been Accredited to provide services within the Facility

Adequate Professional Indemnity Insurance means insurance, including run off/tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to the Facility, and is in an amount and on terms that the Facility considers in its absolute discretion to be sufficient. The insurance must be adequate for Scope of Practice and level of activity.

AHPRA means the Australian Health Practitioner Regulation Agency established under the Health Practitioner Regulation National Law Act 2009 (as in force in each State and Territory) which came into effect on 1 July 2010.

Behavioural Sentinel Event means an episode of inappropriate or problematic behaviour which indicates concerns about an Accredited Practitioner's level of functioning and suggests potential for adversely affecting Patient safety and welfare or organisational outcomes.

Behavioural Standards means the standard of conduct and behaviour expected of an Accredited Practitioner arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners, employees of the Facility, Medical Advisory Committee members, executive of the Facility, third party service providers, Patients, family members of patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Code of Conduct, the expectations set out in the Good Medical Practice: A Code of Conduct for Doctors in Australia (as applicable), and the values set out in By-law 2.

Medical Advisory Committee means the Medical Advisory Committee of Directors of the Facility.

By-laws means these By-laws.

Clinical Practice means the professional activity undertaken by Accredited Practitioners for the purposes of investigating Patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

Code of Conduct means the relevant code of conduct in place at the Facility.

Competence means, in respect of a person who applies for Accreditation or Re-Accreditation, that the person is possessed of the necessary knowledge, skills, training, decision making ability, judgment, insight,

interpersonal communication and Performance necessary for the Scope of Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

Credentials means, in respect of a person who applies for Accreditation or Re-Accreditation, the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) that contribute to the Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services at the Facility. This may include (where applicable and relevant) history of and current status with respect to Clinical Practice and outcomes during previous periods of Accreditation, disciplinary actions, By-law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration and professional indemnity insurance.

Credentialing means, in respect of a person who applies for Accreditation or Re-Accreditation, the formal process used to match the skills, experience, and qualifications to the role and responsibilities of the position. This will include actions to verify and assess the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) for the purpose of forming a view about their Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific environments. Credentialing involves obtaining evidence contained in verified documents to delineate the theoretical range of services which an Accredited Practitioner is competent to perform.

Current Fitness is the current fitness required of an applicant for Accreditation or Re-Accreditation to carry out the Scope of Practice sought or currently held, including with the confidence of peers and the Facility, having regard to any relevant physical or mental impairment, disability, condition or disorder (including due to alcohol, drugs or other substances) which detrimentally affects or there is a reasonably held concern that it may detrimentally affect the person's capacity to provide health services at the expected level of safety and quality having regard to the Scope of Practice sought or currently held

Disruptive Behaviour means aberrant behaviour manifested through personal interaction with Accredited Practitioners, hospital personnel, health care professionals, Patients, family members, or others, which interferes with Patient care or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the values of the Facility

External Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) external to the Facility.

Facility means the PASO Infusion Centre located at Frankston Private Hospital, 5 Susono Way, Frankston VIC 3199.

Director of Nursing means the person appointed to the position of Chief Medical Director, or equivalent position by whatever name such as General Manager or Chief Executive Officer, of the Facility or any person acting, or delegated to act, in that position

Internal Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) internal to the Facility.

Medical Advisory Committee means the Medical Advisory Committee (or equivalent) of the Facility.

Medical Practitioner means, for the purposes of these By-laws, a person registered as a medical practitioner by the Medical Board of Australia governed by the AHPRA pursuant to the Health Practitioner Regulation National Law Act 2009 as in force in each State and Territory.

New Clinical Services means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Facility for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of Accredited Practitioners.

Organisational Capability means the Facility's ability to provide the facilities, services, clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by consideration of, but not limited to, the availability, limitations and/or restrictions of the services, staffing (including qualification and skill-mix), facilities, equipment, technology and support services required and by reference to the Facility's private health licence (where applicable), clinical service capacity and clinical services plan

Patient means a person admitted to, or treated as an outpatient at, the Facility

Performance means the extent to which an Accredited Practitioner provides, or has provided, health care services in a manner which is considered consistent with good and current Clinical Practice and results in expected patient benefits and outcomes. When considered as part of the Accreditation process, Performance will include an assessment and examination of the provision of health care services over the prior periods of Accreditation (if any)

Re-accreditation means the process provided in these By-laws by which a person who already holds Accreditation may apply for and be considered for Accreditation following the probationary period or any subsequent term.

Scope of Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Facility based on the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the organisation to support the Accredited Practitioner's scope of clinical practice. Scope of Practice may also be referred to as delineation of clinical privileges.

Specialist Medical Practitioner means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Cth) and has received specialist registration from the AHPRA.

Temporary Accreditation means the process provided in By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a limited period.

Visiting Medical Practitioner means a Medical Practitioner who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-laws. Visiting Medical Practitioners include visiting Specialist Medical Practitioners.

2.2 Interpretation

Headings in these By-laws are for convenience only and are not to be used as an aid in interpretation.

In these By-laws, unless the context makes it clear the rule of interpretation is not intended to apply, words importing the masculine gender shall also include feminine gender, words importing the singular shall also include the plural, if a word is defined another part of speech has a corresponding meaning, if an example is given the example does not limit the scope, and reference to legislation (including subordinate legislation or regulation) is to that legislation as amended, re-enacted or replaced.

The Chief Medical Director may delegate any of the responsibilities conferred upon him/her by the By-laws in his/her complete discretion, but within any delegation parameters approved by the Medical Advisory Committee.

Any dispute or difference which may arise as to the meaning or interpretation or application of these By-laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the Chief Medical Director. There is no appeal from such a determination by the Chief Medical Director.

2.3 Meetings

Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the relevant committee.

Committee resolutions and decisions, if not specified in the terms of reference, must be supported by a show of hands or ballot of committee members at the meeting.

Voting, if not specified elsewhere, shall be on a simple majority voting basis and only by those in attendance at the meeting (including attendance by electronic means). There shall be no proxy vote.

In the case of an equality of votes, the chairperson will have the casting vote.

A committee established pursuant to these By-laws may hold any meeting by electronic means or by telephonic communication whereby participants can be heard.

Resolutions may be adopted by means of a circular resolution.

Information provided to any committee or person shall be regarded as confidential and is not to be disclosed to any third party or beyond the purpose for which the information was made available.

Any member of a committee who has a conflict of interest or material personal interest in a matter to be decided or discussed shall inform the chairperson of the committee and take no part in any relevant discussion or resolution with respect to that particular matter

3. Introduction

3.1 Purpose of this document

a) This document sets out the terms and conditions on which Medical Practitioners, Allied Health Professionals and other approved categories of health professionals may apply to be Accredited within the defined Scope of Practice granted, the basis upon which a successful applicant may admit Patients and/or care and treat Patients at the Facility, and the terms and conditions for continued Accreditation.

b) Every applicant for Accreditation will review the By-laws and Annexures before making an application. It is an expectation of the Facility that the By-laws are read in their entirety by the applicant as part of the application process. Ignorance of the By-laws will not be regarded as an acceptable excuse.

c) Patient care is provided by Accredited Practitioners who have been granted access to use the Facility and its resources in order to provide that care. The By-laws define the relationship and obligations between the Facility and its Accredited Practitioners.

d) The Facility aims to maintain a high standard of Patient care and to continuously improve the safety and quality of its services. The By-laws implement measures aimed at maintenance and improvements in safety and quality.

e) Health care in Australia is subject to numerous legislation and standards. The By-laws assist in compliance with certain aspects of this regulation but are not a substitute for review of the relevant legislation and standard.

Part B – Terms and Conditions of Accreditation

4. Compliance with By – Laws

4.1 Compliance obligations

a) It is a requirement for continued Accreditation that Accredited Practitioners comply with the By-laws at all relevant times when admitting, caring for or treating Patients, or otherwise providing services at the Facility.
b) Any non-compliance with the By-laws may be grounds for suspension, termination, or imposition of conditions.
c) Unless specifically determined otherwise by the Chief Medical Director in writing for a specified Accredited Practitioner, the provisions of these By-laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written determination by the Chief Medical Director, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-laws and any terms, express or implied, in a contract or employment or engagement.

4.2 Compliance with policies and procedures

Accredited Practitioners must comply with all policies and procedures of, or in place at, the Facility.

4.3 Compliance with legislation

Accredited Practitioners must comply with all relevant legislation, including but not limited to legislation that relates to health, public health, drugs and poisons, privacy, coroners, criminal law, health practitioner registration, research, environmental protection, workplace health & safety, occupational health and safety, anti-discrimination, bullying, harassment, industrial relations, care of persons with a disability, substituted decision making, mental health, Medicare, health insurance, competition and consumer law, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of the Facility.

In addition, Accredited Practitioners must ensure compliance with, or assist the Facility to comply with, any Commonwealth or State mandated service capability frameworks or minimum standards.

4.4 Insurance and registration

Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance.

Accredited Practitioners must at all times maintain registration with AHPRA that is sufficient for the Scope of Practice granted. Accredited Practitioners are required to provide evidence annually, or at other times upon request, of Adequate Professional Indemnity Insurance and registration, and all other relevant licenses or registration requirements for the Scope of Practice granted. If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information, or provide permission for the Facility to obtain that information directly.

4.5 Standard of conduct

a) The Facility expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves in accordance with:
   I. the Code of Conduct;- to be developed
   II. the Code of Ethics of the Australian Medical Association or any other relevant code of ethics;
   III. the Code of Practice of any specialist college or professional body of which the Accredited Practitioner is a member;
   IV. the Values of the Facility.
   V. the strategic direction of the Facility.
   VI. the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-laws; and
   VII. all reasonable requests made with regard to personal conduct in the Facility.

b) Accredited Practitioners must continuously demonstrate Competence and Current Fitness, must not engage in Disruptive Behaviour, and must observe all reasonable requests with respect to conduct and behaviour.

c) Accredited Practitioners must not engage in any conduct that may be perceived as a reprisal against another person for making a report or supplying information relating to breaches in the Code of Conduct.

d) Upon request by the Chief Medical Director the Accredited Practitioner is required to meet with the Chief Medical Director and any other person that the Chief Medical Director may ask to attend the meeting, to discuss matters in (a) to (c) above, or any other matter arising out of these By-laws.

4.6 Notifications

Accredited Practitioners must immediately advise the Chief Medical Director, and follow up with written confirmation within 2 days, should:

a) an investigation or complaint be commenced in relation to the ACCREDITED PRACTIONER, or about his/her Patient (irrespective of whether this relates to a Patient of the Facility), by AHPRA, the Accredited Practitioners registration Medical Advisory Committee, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency.

b) an adverse finding (including but not limited to criticism or adverse comment about the care or services provided by the ACCREDITED PRACTIONER made against the ACCREDITED PRACTIONER by a civil court, AHPRA, the practitioner's registration Medical Advisory Committee, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, irrespective of whether this relates to a Patient of the Facility.

c) the ACCREDITED PRACTIONERs professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a Patient of the Facility and irrespective of whether this is noted on the public register or is privately agreed with a registration Medical Advisory Committee;

d) professional indemnity membership or insurance be made conditional or not be renewed, or should limitations be placed on insurance or professional indemnity coverage;

e) the ACCREDITED PRACTIONERs appointment, clinical privileges or Scope of Practice at any other facility, hospital or day procedure centre alter in any way, including if it is withdrawn, suspended, restricted, or made conditional, and irrespective of whether this was done by way of agreement;
f) any physical or mental condition or substance abuse problem occur that could affect his or her ability to practice or that would require any special assistance to enable him or her to practice safely and competently;
g) the ACCREDITED PRACTIONER believe that Patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another ACCREDITED PRACTIONER of the Facility;
h) the ACCREDITED PRACTIONER make a mandatory notification to a health practitioner registration Medical Advisory Committee in relation to another ACCREDITED PRACTIONER of the Facility; or
i) the ACCREDITED PRACTIONER be charged with having committed or is convicted of a sex, violence or other criminal offence. The Accredited Practitioner must provide the Facility with an authority to conduct at any time a criminal history check with the appropriate authorities.

4.7 Continuous disclosure

a) The Accredited Practitioner must keep the Chief Medical Director continuously informed of every fact and circumstances which has, or will likely have, a material bearing upon:
    I. the Accreditation of the Accredited Practitioner;
    II. the Scope of Practice of the Accredited Practitioner;
    III. the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Scope of Practice, including if the Accredited Practitioner suffers from an illness or disability which may adversely affect his or her Current Fitness;
    IV. the Accredited Practitioner's registration or professional indemnity insurance arrangements; (v) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a Patient; (vi) adverse outcomes, complications, complaints, claims, reportable deaths and coronial investigations in relation to the Accredited Practitioner's Patients (current or former) of the Facility;
    V. the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice; and
    VI. the reputation of the Facility.
b) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Chief Medical Director informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, Patient complaints, health complaints body complaints or investigations, or other inquiries involving Patients of the Accredited Practitioner that were treated at the Facility.

4.8 Representations and media

Unless an Accredited Practitioner has the prior written consent of the Chief Medical Director, an Accredited Practitioner may not use the Facility's name, letterhead, logo, or in any way suggest that the Accredited Practitioner represents these entities.

The Accredited Practitioner must obtain the Chief Medical Director's prior approval before interaction with the media regarding any matter involving the Facility or a Patient

4.9 Committees

a) The Facility requires Accredited Practitioners, as reasonably requested by the Chief Medical Director, to assist it in achieving its objectives through membership of committees of the Facility. This includes committees responsible for developing, implementing and reviewing policies in clinical areas; participating in medical, nursing and other education programs; and attending meetings of Accredited Practitioners.

4.10 Confidentiality

a) Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Facility's policy and the 'Australian Privacy Principles' established by the Privacy Act (Cth), and other legislation and regulations relating to privacy and confidentiality, and will not do anything to bring the Facility in breach of these obligations.
b) Accredited Practitioners will comply with the various legislation governing the collection, handling, security, storage and disclosure of health information, as well as notification of data breaches. This includes the data being used on new/emergent technologies.
c) Accredited Practitioners will comply with common law duties of confidentiality.
d) The following will be kept confidential by Accredited Practitioners:
    I. Commercially in confidence business information concerning the Facility;
    II. The particulars of these By-Laws; (iii) Information concerning the Facility's insurance arrangements;
    III. information concerning any Patient or staff of the Facility;
    IV. information which comes to their knowledge concerning Patients, Clinical Practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services.
e) In addition to statutory or common law exceptions to confidentiality, the confidentiality requirements do not apply in the following circumstances:
    I. where disclosure is required to provide continuing care to the Patient;
    II. where disclosure is required by law;
    III. where disclosure is made to a regulatory or registration body in connection with the Accredited Practitioner, another Accredited Practitioner, or the Facility;
    IV. where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or
    V. where disclosure is required in order to perform some requirement of these By-Laws.
    VI. (f) The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be Accredited.

4.11 Communication within the Facility

Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Medical Advisory Committee , Chief Medical Director, Practice Manager, Committees of the Facility, staff of the Facility and other Accredited Practitioners.

Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information, that may otherwise be restricted by the Privacy

Act. The acknowledgment and consent is given on the proviso that the information will be dealt with in accordance with obligations pursuant to the Privacy Act and only for proper purposes and functions.

5. Safety and quality

5.1 Clinical responsibilities - admission, availability, communication, & discharge

An Accredited Practitioner admitting a patient to PASO INFUSION CENTRE is responsible for the continuity of care and for the discharge of that patient. Amongst other things, he or she must:

a) be always available for contact, either in person or by his or her deputy who must also be accredited to use PASO INFUSION CENTRE.
b) notify the Practice Manager if Accredited Practitioner will be unavailable at any time and nominate an alternative who will care for the patient during Accredited Practitioners absence or unavailability.

Accredited Practitioners must participate in formal on call arrangements as reasonably required by the Facility. Persons providing on-call or cover services must be Accredited by the Facility.

Accredited Practitioners are to ensure any changes to contact details are notified promptly to the Practice Manager. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason.

Accredited Practitioners must only treat Patients within the Scope of Practice granted

PASO INFUSION CENTRE expects Accredited Practitioners to communicate regularly and fully with patients about all aspects of their treatment and to treat patients with courtesy and sensitivity. PASO INFUSION CENTRE stresses the fundamental importance of Accredited Practitioners to responding to patient complaints.

Adequate instructions and written clinical handover is required to be given to the Facility staff and other practitioners (including any on-call cover) to enable them to understand what care the Accredited Practitioners requires to be delivered.

Patient assessment

Accredited Practitioners are to ensure that as part of the preadmission assessment patients are assessed to be appropriate for treatment in the PASO Infusion Centre.

Patient Management

Accredited Practitioners follow policy and procedure for the management of the Facility policy and procedure for the management of the deteriorating patient.

The management of complications and emergencies that may arise during the procedure or in the immediate post-treatment phase are to be managed in accordance with Facility policy and procedure for the management of the deteriorating patient

The Accredited Practitioner must ensure that their Patients are not discharged without complying with the discharge policy and documentation of the Facility and completing all Patient discharge documents required

by the Facility. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the patient, this includes emergency care should it be required. Written instructions **must** be given to the patient including:

a) the treatment undertaken
b) the contact details for the medical practitioner who prescribed the treatment
c) alternative contact details in case the medical practitioner is not available
d) the expected post-treatment symptoms
e) instructions for the patient if they experience unusual pain or symptoms
f) instructions for medication and self-care, and
g) dates and details of follow-up visits.

5.2 Quality and safety

Accredited Practitioners must strictly adhere to PASO INFUSION CENTRE Infection Control policy and procedures relating to patient care

Accredited Practitioners must strictly adhere to PASO INFUSION CENTRE Medication Safety policy and procedures for the safe handling and management of medications

Accredited Practitioners must strictly adhere to PASO INFUSION CENTRE policy and procedures that support procedural matching and patient identification

Accredited Practitioners are expected to comply with PASO INFUSION CENTRE Work Health and Safety policies and procedures to ensure the safety of themselves, staff and patients. Accredited Practitioners must not place themselves or others at risk. Workplace accidents or incidents should be notified to the Practice Manager to ensure appropriate risk management procedures are implemented.

Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for Patients. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Facility executive, Patients and the Patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

Accredited Practitioners must appropriately supervise the care that is provided by the Facility staff and other practitioners. This includes providing adequate instructions to, and supervision of trainees and Facility staff to enable staff to understand what care the Accredited Practitioner requires to be delivered.

Accredited Practitioners must encourage and support clinical and patient care review, evaluate their own services and performance and use such information to supply optimal patient care.

Accredited Practitioners should send all copies of quality management activity reports (either formal review studies and/or topics of clinical meetings) to the Medical Advisory Committee

Should an Accredited Practitioners become aware of a clinical situation, which may pose a medico-legal risk for the PASO INFUSION CENTRE they should put in an incident report and advise the Chief Medical Director.

5.3 Administration of oncology treatments

Accredited Practitioners acknowledge the importance of, and will strictly adhere to, various measures aimed at ensuring safety and quality during the provision of treatments which includes but is not limited to participating in or allowing to occur procedures relating to correct treatment to correct patient, team time out.

Accredited Practitioners are to take due care and diligence in the safe, competent, efficient use of equipment, resources and consumables. The Accredited Practitioner will ensure that they have undertaken and continue to maintain appropriate training and skills to effectively and efficiently use PASO Infusion Centre equipment, resources and consumables in a safe manner. Where equipment and or instrumentation require maintenance and or repair, Accredited Practitioners are to notify the Practice Manager immediately

5.4 Facility, State Based and National Safety Programs, Initiatives and Standards

Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by the Facility based upon its own safety and quality program, or safety and quality initiatives, programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations (including for example the national Australian Commission on Safety and Quality in Health Care, a State based division of a Health Department, or a State based independent statutory body).

Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that the Facility elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are imposed upon the Facility and require assistance from the Accredited Practitioner to ensure compliance, including but not limited to the National Safety and Quality Health Service Standards and Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care.

5.5 Treatment and financial consent

Accredited Medical Practitioner must obtain fully informed consent for treatment from the Patient or their legal guardian or substitute decision maker in accordance with accepted medico legal standards and in accordance with the policy and procedures of the Facility.

The consent will be evidenced in writing and signed by the Medical Practitioner and Patient or their legal guardian or substitute decision maker.

It is expected that fully informed consent will be obtained by the Accredited Medical Practitioner under whom the Patient is admitted or treated, in accordance with the Medical Practitioner's non delegable duty of care. The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment and alternatives, inform the Patient of material risks associated with treatment and alternatives and the use and storage of patients' before and after photos; and then obtain the consent to treatment.

It is expected that the Accredited Medical Practitioner will ensure:

a) that information is provided in a language understood by the consumer
b) provides the short- and long-term potential outcomes/complications of the planned surgery / treatment
c) detail about the full range of complaints mechanisms available to the patient.

Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their Patients in accordance with the relevant legislation, health fund agreements, policy and procedures of the Facility.

5.6 Medical Records

Accredited Medical Practitioners must ensure that:

a) Patient records held by the Facility are adequately maintained for Patients treated by the Medical Practitioner;
b) Patient records satisfy the Facility Medical Records policy requirements, legislative requirements (consent), accreditation requirements, and health fund obligations;
c) they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the Patient, with the entries dated, time and signed;
d) they comply with all legal requirements and standards in relation to the prescription and administration of medication, and properly document all drugs orders clearly and legibly in the medication chart maintained by the Facility;
e) Patient records include all relevant information and documents reasonably necessary to allow Facility staff and other Accredited Practitioners to care for Patients;
f) A procedure report is completed including a detailed account of the findings, technique undertaken, complications and post treatment orders.
g) A discharge summary is to be completed that includes all relevant information reasonably required by a treating practitioner for ongoing care of the Patient should this be required and for the patient. This is to include:
    I. The treatment provided
    II. the contact details of the medical practitioner who prescribed the treatment
    III. alternative contact details in case the medical practitioner is not available
    IV. the expected post-treatment symptoms
    V. instructions for the patient if they experience unusual pain or symptoms
    VI. instructions for medication and self-care, and
    VII. dates and details of follow-up visits.

5.7 Financial information and statistics

a) Accredited Practitioners must record all data required by the Facility to meet health fund obligations, collect revenue and allow compilation of health care statistics.
b) Accredited Practitioners must ensure that all Pharmaceutical Benefits Scheme prescription requirements are completed in accordance with Facility policy and regulatory requirements

5.8 Quality improvement, risk management and regulatory agencies

a) Accredited Practitioners are required to attend and participate in the Facility's safety, quality, risk management, education and training activities, including clinical practice review and peer review activities, and as required by relevant legislation, standards and guidelines (including those standards and guidelines set by relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care). This includes a requirement to meaningfully participate in clinical review committee

meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting

b) Accredited Practitioners will report to the Facility incidents, complications, adverse events, deaths and complaints (including in relation to the Accredited Practitioner's Patients) in accordance with the Facility policy and procedures and where required by the Chief Medical Director will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), complaints management, and open disclosure processes

c) Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Facility of risk management strategies and recommendations from system reviews, and will maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to the approved Scope of Practice. Where requested and, as part of Accreditation applications, Accredited Practitioners will provide evidence of external education and continuing professional development.

d) Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Facility requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or from a health complaints body, AHPRA, Coroner, Police, State Health Department and its agencies or departments, Private Health Unit, and Commonwealth Government and its agencies or departments.

e) To comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines.

5.9 Clinical Care committees

1. Clinical Review Committee

The Chief Medical Director will establish a clinical review committee for the purpose of reviewing and advising on performance of the clinical care and outcomes. This committee may include but are not limited to peer review and quality activities and operate as a subcommittee of the Medical Advisory Committee. The Clinical Review Committee must be held a minimum of every three (3) months. The Clinical Review Committee Meeting minutes will be tabled at the Medical Advisory Committee Meetings.

2. Quality and Safety Committee

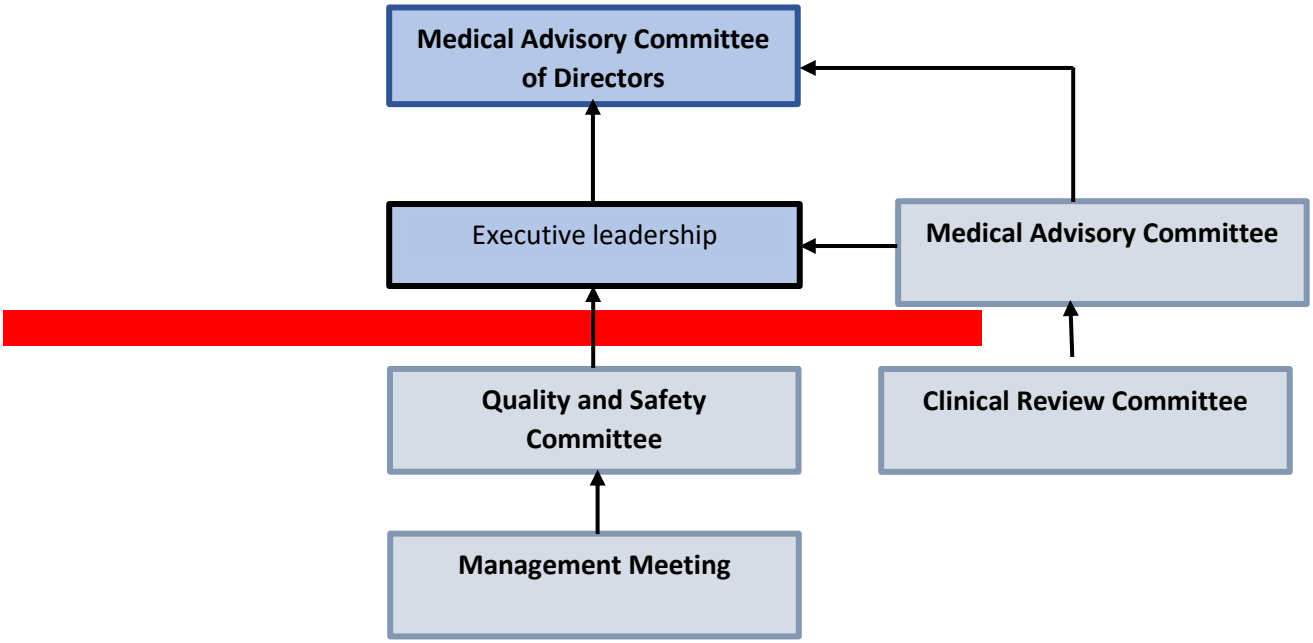
The Quality and safety committee will meet every three (3) months following a Clinical Review Committee meeting and address the matters as outlined in the terms of reference. The Quality and Safety Committee will report to the Medical Advisory Committee 6 monthly (or more frequently as adhoc if there is a need to report specific events during that time)

The leadership group maintain accountability for developing, actioning and reviewing all quality and safety requirements, (as per NSQSHC standards 2021 2nd ed.,) initiatives relating to quality and safety activity and monitor the quality and safety indicators through the Risk Management System.

3. Medical Advisory Committee

The Medical Advisory Committee meet twice per year as per the terms of reference. They support the leadership team and Medical Advisory Committee in the monitoring, managing and maintenance of medico legal issues, clinical practice, credentialling, quality and safety.

Committee Structure



5.10 Facility Assets

All Accredited Practitioners are to abide by the Facilities policies and procedures for the safe, competent and efficient use of equipment and resources provided at the Facility. Evidence of damage of equipment and/or inefficient use of resources of the Facility may require updating of competence / training on use for that equipment and/or resource. All Facility equipment is to be used / operated within manufacturer and Facility guidelines to ensure optimal patient care is delivered through due care and diligence.

Part C – Accreditation of Medical Practitioners

6. Credentialing and Scope of Practice

6.1 Eligibility for Accreditation as Medical Practitioners

Accreditation as Medical Practitioners will only be granted if Medical Practitioners demonstrate adequate Credentials, are professionally Competent, satisfy the requirements of the By-laws, and are prepared to comply with the By-laws and the Facility policies, and provide written acknowledgment of such preparedness.

6.2 Entitlement to treat Patients at the Facility

a) Medical Practitioners who have received Accreditation pursuant to the By-laws are entitled to make a request for access to facilities for the treatment and care of their Patients within the limits of the defined Scope of Practice attached to such Accreditation at the Facility and to utilise facilities provided by the Facility for that purpose, subject to the provisions of the By-laws, Facility policies and resource limitations of the Facility.
b) A Medical Practitioner's use of the facilities for the treatment and care of Patients is limited to the Scope of Practice granted by the Chief Medical Director and subject to the conditions upon which the Scope of Practice is granted, and resource limitations of the Facility.

6.3 Responsibility and basis for Accreditation and granting of Scope of Practice

The Chief Medical Director will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant. In making any determination, the Chief Medical Director will make independent and informed decisions and in so doing will have regard to the matters set out in these By-laws and will have regard to the recommendations of the Medical Advisory Committee. The Chief Medical Director may, at his/her discretion, consider other matters as relevant to the application when making his/her determination.

6.4 Medical Advisory Committee

The Chief Medical Director shall convene a Medical Advisory Committee (MAC) in accordance with the terms of reference established for the MAC. The MAC is the senior coordinating body of medical services supplied by PASO INFUSION CENTRE. It is responsible for, and reports to, the Chief Medical Director.

The MAC members, including the chairperson, will be appointed by the Chief Medical Director for such period as determined by the Medical Advisory Committee and may be removed from membership of the committee by the Medical Advisory Committee.

In the absence of a Credentialing Committee, this role will be performed by the MAC. Where recommendations relating to Credentialing are discussed and undertaken, and the role is performed by the MAC, the terms of reference are to include a process that provides for closing the MAC meeting and reconvening it as a Credentialing Committee meeting, including the recording of separate minutes.

In addition to the terms of reference established for the MAC, the Committee must be constituted according to and the members of the Committee must conduct themselves in accordance with any

legislative obligations, including standards that have mandatory application to the Facility and Committee members.

The Director of Nursing will be entitled to attend meetings of the MAC as ex-officio members, such that they will not have an entitlement to vote in relation to decisions or recommendations of the MAC.

In making determinations about applications for Accreditation there is to be at least one member of the same specialty as the applicant on the MAC, to assist with the determination.

7. The process for appointment and re-appointment

Applications for Initial Accreditation and Re-Accreditation as Medical Practitioners

a) Applications for Initial Accreditation (where the applicant does not currently hold Accreditation at the Facility) and Re-Accreditation (where the applicant currently holds Accreditation at the Facility) as Medical Practitioners must be made in writing on the prescribed form. All questions on the prescribed form must be fully completed and all required information and documents supplied before an application will be considered. Applications should be forwarded to the Chief Medical Director at least six weeks prior to the Medical Practitioner seeking to commence at the Facility
b) Applications must include a declaration signed by the Medical Practitioner to the effect that the information provided by the Medical Practitioner is true and correct, that the Medical Practitioner will comply in every respect with the By-laws in the event that the Medical Practitioner's application for Accreditation is approved
c) The Chief Medical Director may interview and/or request further information from applicants that the Chief Medical Director considers appropriate.
d) The Chief Medical Director will ensure that applications are complete and requests for further information complied with, and upon being satisfied will refer applications, together with notes from any interview conducted, to the Medical Advisory Committee for consideration.

7.2 Consideration by the Medical Advisory Committee

a) The Medical Advisory Committee will consider all applications for Accreditation and Re-Accreditation referred to it by the Chief Medical Director.
b) Consideration by the Medical Advisory Committee will include but not be limited to information relevant to Credentials, Competence, Current Fitness and Organisational Capability
c) The Medical Advisory Committee will make recommendations as to whether the applications should be approved and if so, on what terms, including the Scope of Practice to be granted.
d) The Medical Advisory Committee will act and make recommendations in accordance with its terms of reference and any relevant policy, as amended from time to time, including in relation to the consideration of applications for Accreditation and Re-Accreditation.
e) In instances where the Medical Advisory Committee has doubts about a Medical Practitioner's ability to perform the services, procedures or other interventions which may have been requested for inclusion in the Scope of Practice, they may recommend to:
f) initiate an Internal Review;
    I. initiate an External Review;

II. grant Scope of Practice for a limited period of time followed by review;
III. apply conditions or limitations to Scope of Practice requested; and/or
IV. apply requirements for relevant clinical services, procedures or other interventions to be performed under supervision or monitoring.

g) If the Medical Practitioner's Credentials and assessed Competence and performance do not meet the Threshold Credentials (if any) established for the requested Scope of Practice (if any), the Medical Advisory Committee may recommend refusal of the application.

7.3 Initial Accreditation tenure

a) Initial Accreditation as a Medical Practitioner at the Facility may, at the decision of the Medical Advisory Committee, be for a probationary period of one year.
b) Prior to the end of any probationary period established pursuant to By-law 8.3(a), a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability, and confidence in the Medical Practitioner will be undertaken by the Chief Medical Director. The Chief Medical Director will seek assistance with the review from the relevant Medical Advisory Committee. The Chief Medical Director may initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is evidence of Sentinel Events exhibited by the Medical Practitioner.
c) In circumstances where, in respect of a Medical Practitioner:
V. a review conducted by the Chief Medical Director at the end of the probationary period, or
VI. a review conducted by the Chief Medical Director at any time during the probationary period, causes the Chief Medical Director to consider:
VII. the Medical Practitioner's Scope of Practice should be amended, or
VIII. the probationary period should be terminated, or
IX. the probationary period should be extended, or
X. the Medical Practitioner should not be offered Re-accreditation, the Medical Practitioner will be:
XI. notified of the circumstances which have given rise to the relevant concerns, and
XII. be given an opportunity to be heard and present his/her case.

a) Should the Medical Practitioner have an acceptable probationary Accreditation review outcome, or in circumstances where Initial Accreditation is granted without a probationary period, the Chief Medical Director, in consultation with the MAC, may grant an Accreditation period of up to three years on receipt of a signed declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as per the By-laws.
b) Should the probationary Accreditation review outcome be unacceptable to the Chief Medical Director, they may, in consultation with the Medical Advisory Committee:
I. amend the Scope of Practice granted; or
II. decide that Accreditation will not be granted.

7.4 Re-Accreditation

a) The Chief Medical Director will, at least three months prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), provide to that Medical Practitioner an application form to be used in applying for Re-Accreditation.
b) Any Medical Practitioner wishing to be Re-Accredited must send the completed application form to the Chief Medical Director at least two months prior to the expiration date of the Medical Practitioner's current term of Accreditation.
c) The Medical Advisory Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for Initial Accreditation as Medical Practitioners.
d) The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners are set out in these By-Laws.
e) Documentation of all re accreditation processes is to be managed in RiskClear.

7.5 Re-Accreditation tenure

Granting of Accreditation and Scope of Practice subsequent to the any probationary period will be for a term of up to three years

8. Review of Accreditation or Scope of Practice

The Chief Medical Director may initiate review of Accreditation or Scope of Practice

a) The Chief Medical Director in conjunction with the Medical Advisory Committee may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where concerns or an allegation are raised about any of the following:
    I. Patient health or safety could be compromised;
    II. the rights or interests of a Patient, staff or someone engaged in or at the Facility has been
    III. adversely affected or could be infringed upon;
    IV. non-compliance with the Code of Conduct
    V. the Medical Practitioner's level of Competence;
    VI. the Medical Practitioner's Current Fitness to practice ;
    VII. the Medical Practitioner's Performance;
    VIII. compatibility with Organisational Capability
    IX. the current Scope of Practice granted does not support the care or treatment sought to be undertaken by the Medical Practitioner;
    X. confidence in the Medical Practitioner;
    XI. compliance with these By-laws, including terms and conditions;
    XII. a possible ground for suspension or termination of Accreditation may have occurred;
    XIII. the efficient operation of the Facility could be threatened or disrupted, the potential loss of the Facility's license or accreditation, or the potential to bring the Facility into disrepute;
    XIV. a breach of a legislative or legal obligation of the Facility or imposed upon the Accredited Practitioner may have occurred; or
    XV. as elsewhere defined in these By-laws.

b) The Chief Medical Director will determine whether the process to be followed is an;
c) Internal Review; or
d) External Review.
e) Prior to determining whether an Internal Review or External Review will be conducted, the Chief Medical Director may in his or her absolute discretion meet with the Medical Practitioner, along with any other persons the Chief Medical Director considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally as determined by the Chief Medical Director) before the Chief Medical Director makes a determination whether a review will proceed, and if so, the type of review.
f) The review may have wider terms of reference then a review of the Medical Practitioner's Accreditation or Scope of Practice.
g) The Chief Medical Director must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Medical Practitioner pending the outcome of the review and, if imposed, there is no right of appeal from this interim decision pursuant to the By-laws
h) In addition or as an alternative to conducting an internal or external review, the Chief Medical Director will notify the Medical Practitioner's registration Medical Advisory Committee and/or other professional body responsible for the Medical Practitioner of details of the concerns raised if required by legislation, otherwise the Chief Medical Director may notify if the Chief Medical Director considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, or it is considered that the registration Medical Advisory Committee or professional body is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the registration Medical Advisory Committee and/or other professional body the Chief Medical Director may elect to take action, or further action, under these By-laws

8.2 Internal Review of Accreditation and Scope of Practice

a) The Chief Medical Director will establish the terms of reference of the Internal Review and may seek assistance of the Medical Advisory Committee for the Internal Review as determined by the Chief Medical Director.
b) The process will ordinarily include the opportunity for submission from the Medical Practitioner, which may be written and/or oral.
c) A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the Medical Advisory Committee.
d) Following consideration of the report, the Medical Advisory Committee will make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner’s Accreditation in accordance with these By-laws.
e) The Chief Medical Director will notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal, if relevant.
f) The Medical Practitioner shall have the rights of appeal established by these By-laws in relation to the final determination made by the Medical Advisory Committee if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

8.3 External Review of Accreditation and Scope of Practice

a) The Chief Medical Director will make a determination about whether an External Review will be undertaken.
b) An External Review will be undertaken by a person(s) external to the Facility and of the Accredited Medical Practitioner in question and such person(s) will be nominated by the Medical Advisory Committee
c) The process will ordinarily include the opportunity for submission from the Medical Practitioner, which may be written and/or oral.
d) The external reviewer is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Chief Medical Director and Medical Advisory Committee.
e) The Chief Medical Director will review the report from the External Review and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Medical Practitioner's Accreditation or Scope of Practice in accordance with these By-laws.
f) The Chief Medical Director must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
g) The Medical Practitioner shall have the rights of appeal established by these By-laws in relation to the final determination made by the Chief Medical Director if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.
h) In addition, or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Chief Medical Director will notify the Medical Practitioner's registration Medical Advisory Committee and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation.

9. Suspension, termination, imposition of conditions, resignation and expiry of Medical Practitioner's Accreditation

9.1 Suspension of Accreditation

a) The Chief Medical Director may immediately suspend a Medical Practitioner's credentials to practice (Accreditation) should the Chief Medical Director believe, or have a sufficient concern:
    I. it is in the interests of patient care or safety. This can be based upon an investigation by an external agency including a registration Medical Advisory Committee, disciplinary body, Coroner or health complaints body, and may be related to a patient
    II. the continuance of the current Scope of Practice raises a significant concern about the safety and quality of health care to be provided by the Medical Practitioner;
    III. (it is in the interests of staff welfare or safety;
    IV. serious and unresolved allegations have been made in relation to the Medical Practitioner. This may be related to a patient
    V. the Medical Practitioner fails to observe the terms and conditions of his/her Accreditation
    VI. the behaviour or conduct is in breach of a direction or an undertaking, or the Facility By-Laws, policies and procedures;

VII. the behaviour or conduct is such that it is unduly hindering the efficient operation of the Facility at any time, is bringing the Facility into disrepute, does not comply with the code of conduct, is considered disruptive or a Sentinel Event or inconsistent with the values of the Facility;

VIII. the Medical Practitioner has been suspended by their registration Medical Advisory Committee.

IX. there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration Medical Advisory Committee or other relevant disciplinary body or professional standards organisation for the Medical Practitioner;

X. the Medical Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former Patient of the Facility;

XI. the Medical Practitioner has made a false declaration or provided false or inaccurate information to the Facility, either through omission of important information or inclusion of false or inaccurate information;

XII. the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-laws or based upon the information contained in a notification suspension is considered appropriate;

XIII. the Accreditation, clinical privileges or Scope of Practice of the Medical Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;

XIV. the Medical Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;

XV. the Medical Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;

XVI. based upon a finalised Internal Review or External Review pursuant to these By-laws any of the above criteria for suspension are considered to apply;

XVII. an Internal Review or External Review has been initiated pursuant to these By-laws and the Chief Medical Director considers that an interim suspension is appropriate pending the outcome of the review; or

XVIII. there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for suspension.

b) The Chief Medical Director shall notify the Medical Practitioner of:

I. the fact of the suspension;

II. the period of suspension

III. the reasons for the suspension;

IV. if the Chief Medical Director considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner, including a response as to why the Medical Practitioner may consider the suspension should not be enforced.

V. if Chief Medical Director considers it applicable and appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and
VI. the right of appeal, the appeal process and the time frame for an appeal.

c) As an alternative to an immediate suspension, the Chief Medical Director may elect to deliver a show cause notice to the Medical Practitioner advising of:

I. the facts and circumstances forming the basis for possible suspension;
II. the grounds under the By-Laws upon which suspension may occur;
III. invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider suspension is not appropriate;
IV. if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and
V. a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Chief Medical Director will determine whether the credentials to practice (Accreditation) will be suspended. If suspension is to occur notification will be sent in accordance with paragraph (b). Should suspension not occur, this will not prevent the Chief Medical Director from taking other action at this time, including imposition of conditions, and will not prevent the Chief Medical Director from relying upon these matters as a ground for suspension or termination in the future.

Ordinarily suspension will be suspension of credentials to practice (Accreditation) in its entirety, however the Chief Medical Director may determine for a particular case that the suspension will be a specified part of the Scope of Practice previously granted and these By-laws in relation to suspension will apply to the specified part of the Scope of Practice that is suspended.

d) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Chief Medical Director.

e) The affected Medical Practitioner shall have the rights of appeal established by these By-laws. (f) The Chief Medical Director will notify the Medical Advisory Committee and Medical Advisory Committee of any suspension of Accreditation.

10.Termination of Accreditation

a) Accreditation shall be immediately terminated by the Chief Medical Director if the following has occurred, or if it appears based upon the information available to the Chief Medical Director the following has occurred:
I. the Medical Practitioner ceases to be registered with their relevant registration Medical Advisory Committee.
II. the Medical Practitioner ceases to maintain Adequate Professional Indemnity Insurance covering the Scope of Practice.

III. a term or condition that attaches to an approval of Accreditation is breached, not satisfied, or according to that term or condition results in the Accreditation concluding; or
IV. a contract of employment or to provide services is terminated or ends, and is not renewed.

b) Accreditation may be terminated by the Chief Medical Director, if the following has occurred, or if it appears based upon the information available to the Chief Medical Director the following has occurred:
   I. based upon any of the matters in By-Law 10.1(a) and it is considered suspension is an insufficient response in the circumstances;
   II. based upon a finalised Internal Review or External Review pursuant to these By-laws and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Chief Medical Director does not have confidence in the continued appointment of the Medical Practitioner.
   III. the Medical Practitioner is not regarded by the Chief Medical Director as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Chief Medical Director does not have confidence in the continued appointment of the Medical Practitioner.
   IV. conditions have been imposed by the Medical Practitioner's registration Medical Advisory Committee on clinical practice that restricts practice, and the Facility elects not to accommodate the conditions imposed.
   V. The Medical Practitioner has not exercised Accreditation or utilised the facilities at the Facility for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Medical Practitioner by the Chief Medical Director.
   VI. the Medical Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-laws be a continuous period of six months' incapacity; or
   VII. there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for termination.

c) The Accreditation of a Medical Practitioner may be terminated as otherwise provided in these By-laws.

d) The Chief Medical Director shall notify the Medical Practitioner of:
   I. the fact of the termination;
   II. the reasons for the termination
   III. if the Chief Medical Director considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner because they may consider a termination should not have occurred; and
   IV. if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.

e) As an alternative to an immediate termination, the Chief Medical Director may elect to deliver a show cause notice to the Medical Practitioner advising of:
   V. the facts and circumstances forming the basis for possible termination;
   VI. the grounds under the By-Laws upon which termination may occur;
   VII. invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider termination is not appropriate;

VIII. if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and (v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Chief Medical Director will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with paragraph (d). Should termination not occur this will not prevent the Chief Medical Director from taking other action at this time, including imposition of conditions, and will not prevent the Chief Medical Director from relying upon these matters as a ground for suspension or termination in the future.

f) All terminations must be notified to the Medical Advisory Committee and Medical Advisory Committee.
g) For a termination of Accreditation pursuant to By-law 10.2(a),
h) there shall be no right of appeal.
i) For a termination of Accreditation pursuant to By-law 10.2(b),
j) the Medical Practitioner shall have the rights of appeal established by these By-laws.
k) Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Chief Medical Director to the Medical Practitioner's registration Medical Advisory Committee and/or other relevant regulatory agency
l) Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that a termination of Accreditation carried out in accordance with these By-laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.
m) As a separate right and despite anything set out above in By-law 10.2, the Chief Medical Director may terminate the Accreditation of an Accredited Practitioner without being required to provide reasons, by ordinarily providing no less than three (3) months written notice, or such other shorter or longer period as the Chief Medical Director considers reasonable in the circumstances. There will be no right of appeal pursuant to these By-laws from such a decision of the Chief Medical Director.

10.1 Imposition of conditions

a) At the conclusion of or pending finalisation of a review, or in lieu of a suspension or in lieu of a termination the Chief Medical Director may elect to impose conditions on the Accreditation or Scope of Practice
b) The Chief Medical Director must notify the Medical Practitioner in writing of the imposition of conditions, the reasons for it, the consequences if the conditions are breached, and advise of the right of appeal, the appeal process and the timeframe for an appeal.
c) If the Chief Medical Director considers it applicable and appropriate in the circumstances, they may also invite a written response from the Medical Practitioner as to why the Medical Practitioner may consider the conditions should not be imposed.
d) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Chief Medical Director.
e) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.
f) If there is held, in good faith, a belief that the continuation of the unconditional right to practice in any other organisation would raise a significant concern about the safety and quality of health care

for patients and the public, the Chief Medical Director will notify the Medical Practitioner's registration Medical Advisory Committee and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

g) Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that an imposition of conditions carried out in accordance with these By-laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

Resignation and expiry of Accreditation

A Medical Practitioner may resign his/her Accreditation by giving one month's notice of the intention to do so to the Chief Medical Director, unless a shorter notice period is otherwise agreed by the Chief Medical Director.

If an application for Re-Accreditation is not received within the timeframe provided for in these By-laws, unless determined otherwise by the Chief Medical Director, the Accreditation will expire at the conclusion of its term. If the Medical Practitioner wishes to admit or treat Patients at the Facility after the expiration of Accreditation, an application for Accreditation must be made as an application for Initial Accreditation.

11. Appeal rights and procedure

11.1 Rights of appeal against decisions affecting Accreditation

a) There shall be no right of appeal against a decision to not approve initial Accreditation or continuation of Accreditation. – needs to be agreed to or not
b) Should an appeal be agreed as per these By – Laws, the process is as follows:

11.2 Appeal process

a) A Medical Practitioner shall have fourteen (14) days from the date of notification of a decision to which there is a right of appeal in these By-laws to lodge an appeal against the decision.
b) An appeal must be in writing to the Chief Medical Director and received by the Chief Medical Director within the fourteen (14) day appeal period or else the right to appeal is lost.
c) Unless decided otherwise by the Chief Medical Director in the circumstances of the particular case, which will only be in exceptional circumstances, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.
d) Upon receipt of an appeal notice the Chief Medical Director will immediately forward the appeal request to the chairperson of the Medical Advisory Committee
e) The chairperson of the Medical Advisory Committee will nominate an Appeal Committee to hear the appeal, establish terms of reference, and submit all relevant material to the chairperson of the Appeal Committee.
f) The Appeal Committee shall comprise at least three (3) persons and will include:
    I. a nominee of the chairperson of the Medical Advisory Committee, who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Medical Practitioner, and who will be the chairperson of the Appeal Committee;

II. a nominee of the Chief Medical Director, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Medical Practitioner.

III. any other member or members who bring specific expertise to the decision under appeal, as determined by the chairperson of the Medical Advisory Committee, who must be independent of the decision under appeal regarding the Medical Practitioner, and who may be an Accredited Practitioner. The chairperson of the Medical Advisory Committee in their complete discretion may invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (i) and (ii) above) but is not bound to follow the suggestions or comments.

g) Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the chairperson of the Medical Advisory Committee will notify the appellant of the members of the Appeal Committee.

h) Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant shall be provided with at least 14 days' notice of the date for determination of the appeal by the Appeal Committee. The notice from the Appeal Committee will ordinarily set out the date for determination of the appeal, the members of the Appeal Committee, the process that will be adopted, and will invite the appellant to make a submission about the decision under appeal. Subject to an agreement to confidentiality from the appellant, the chairperson of the Appeal Committee may provide the appellant with copies of material to be relied upon by the Appeal Committee.

i) The appellant will be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.

j) If the appellant elects to provide written submissions to the Appeal Committee, following such a request from the Appeal Committee for a written submission, unless a longer time frame is agreed between the appellant and Appeal Committee the written submission will be provided within 7 days of the request.

k) The Chief Medical Director (or nominee) may present to the Appeals Committee in order to support the decision under appeal.

l) If the appellant attends before the Appeal Committee to answer questions and to make submissions, the appellant is not entitled to have formal legal representation at the meeting of the Appeal Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeal Committee.

m) The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.

n) The chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.

o) The Appeal Committee will make a written recommendation regarding the appeal to the chairperson of the Medical Advisory Committee, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal

Committee and if an even number of Appeal Committee members then the chairperson has the deciding vote. A copy of the recommendation will be provided to the appellant.

p) The Medical Advisory Committee will consider the recommendation of the Appeal Committee and make a decision about the appeal.
q) The decision of the Medical Advisory Committee will be notified in writing to the appellant.
r) The decision of the Medical Advisory Committee is final and binding, and there is no further appeal allowed under these By-Laws from this decision.
s) If a notification has already been given to an external agency, such as a registration Medical Advisory Committee, then the Medical Advisory Committee will notify that external agency of the appeal decision. If a notification has not already been given, the Medical Advisory Committee will make a determination whether notification should now occur based upon the relevant considerations for notification to an external agency as set out in these By-laws relating to the decision under appeal.

Part D – Amending By-laws, annexures, and associated policies and procedures

Amendments to, and instruments created pursuant to, the By-laws

a) Amendments to these By-laws can only be made by approval of the Medical Advisory Committee.
b) All Accredited Practitioners will be bound by amendments to the By-laws from the date of approval of the amendments by the Medical Advisory Committee, even if Accreditation was obtained prior to the amendments being made. If amendments are to have retrospective application, this must be specifically stated by the Medical Advisory Committee.
c) The Medical Advisory Committee may approve any annexures that accompany these By-laws, and amendments that may be made from time to time to those annexures, and the annexures once approved by the Medical Advisory Committee are integrated with and form part of the By-laws. The documents contained in the annexures must be utilised and are intended to create consistency in the application of the processes for Accreditation and granting of Scope of Practice.
d) The Medical Advisory Committee may approve forms, terms of reference and policies and procedures that are created pursuant to these By-laws or to provide greater detail and guidance in relation to implementation of aspects of these By-laws.

Audit and Compliance

The Chief Medical Director will establish a regular audit process, at intervals determined to be appropriate by the Chief Medical Director or as may be required by a regulatory authority, to ensure compliance with and improve the effectiveness of the processes set out in these By-laws relating to Credentialing and Accreditation, and any associated policies and procedures, including adherence by Accredited Practitioners to approved Scope of Practice.

The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the Medical Advisory Committee by the Chief Medical Director.